

Our claim is that by this method we can obtain all that can be obtained by the use of the "Yes/No" method, but with greater precision. It appears from their statement, "For these purposes the simple Yes/No answer seems to work pretty well," that Drs. Fletcher and Tinker are willing to accept a low level of accuracy. Surely it is much sounder to gather data in the most accurate way practical, even though some may be discarded later. Drs. Fletcher and Tinker admit that their technique breaks down in "some borderline cases which are arbitrarily classed as negative," but when it is the *patient* who is left to resolve any ambiguities it is impossible to estimate how many decisions are borderline, so the amount of negative bias is unknown.

Drs. Fletcher and Tinker suggest that their method is validated by a comparison of the results of two independent surveys on the "relationship between answers to questions and winter sputum volumes in two male populations" (Table VIII, May 27, p. 1495). By their technique the patient has three alternatives, "Not at all," "Part of the time," and "All the time." It is apparent that the middle category contains all but the two extremes and so is much wider than the other two categories. Hence it is not surprising that the results of the two independent surveys show no disagreement for the two extreme categories but show a significant ($P=0.05$) *disagreement* for the middle category. Had a continuous scale been used in place of the three categories by asking the question, "How much of the time do you bring up sputum?" the results of the two surveys could have been compared with greater accuracy.

With regard to the question of fallible memories, we fully recognize the dangers of retrospective surveys, but consider that any such objection applies equally to all questionnaire techniques. In the one investigation we have conducted in which it has been possible to estimate the importance of distortion due to the time elapsed between the events and their recall, it was found to be negligible compared with the main effects in which we were interested. However, there can be no general solution to this problem; it needs to be examined afresh in each investigation.—We are, etc.,

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Congenital Dislocation of the Hip

SIR,—Mr. Gavin C. Gordon's letter on congenital dislocation of the hip (July 29, p. 311) raises a point of very considerable interest, but first let me point out an error. He states, "All newborn infants have slack or loose hips to some extent." This is not correct. Out of 8,200 children examined in the first week of life only 113 had lax hips, in all the others the hips were absolutely stable.

Mr. Gordon then goes on to say "many cases of congenital dislocation of the hip do not make their appearance until the child begins to walk. . . ." There is of course a difference in being present and making their appearance. Can Mr. Gordon, or anyone else, *prove* that these hips had not been dislocated for a long time before they were found? Out of these 8,200 children 5,865 are now 1 year old, and so far not a single child among those who started with normal hips has subsequently developed any abnormality. It would therefore seem likely that if congenital dislocation makes its appearance after birth such an event must be extremely rare.

I agree with Mr. Gordon when he says that "clunking" or "clonking" can frequently be elicited

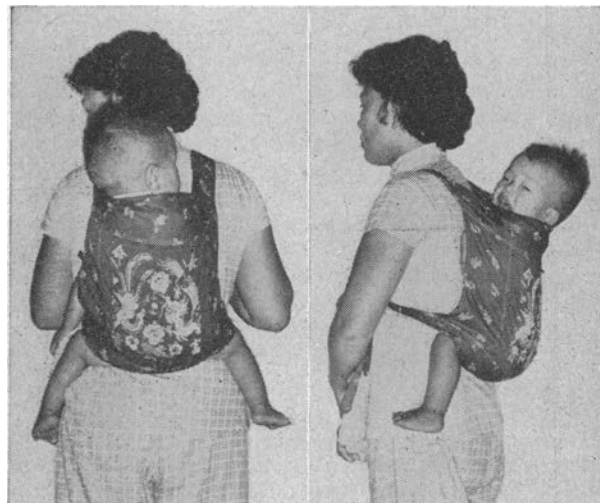
recover spontaneously, but I feel that there is a very strong case for supposing that these lax hips also include nearly all, if not all, the congenital dislocations. I am well aware of the view that congenital dislocation can occur after birth either when the legs are extended or when the child first walks, but is this a proven point, or is it a surviving conception and belief of ancient medicine?—I am, etc.,

Salford.

T. G. BARLOW.

SIR,—It was good to read Mr. Norman Capener's letter (July 1, p. 47) and to see that the work of von Rosen and his colleagues in Malmo was being appreciated in Britain.

I thought that your readers might like to see the way the Chinese in Hong Kong treat their children from birth. The picture shows the method of carrying the infants in Hong Kong, which is both practical and convenient, the mother often working with the child happily asleep on the back.



It may interest you to know that in the past ten years we have seen ten cases of congenital dislocation of the hip among a population of three million odd, and that in each case the baby had not been carried on the mother's back, but had been brought up in Western style with bulky napkins and the legs pulled down and contained within blankets in a pram and cot.—I am, etc.,

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Skin Disease in Africa

SIR,—I write this letter in reply to Dr. James Marshall's inquiry regarding skin disease in Africa (May 27, p. 1544).

I have collected the following common skin diseases one sees in Ghana: (1) onchodermatitis, which manifests itself as (a) acute urticarial reaction, (b) pruritus, (c) generalized septic dermatitis, (d) generalized oval plaques brownish-purple in colour, (e) patches of depigmentation; (2) tinea (all forms): *T. corporis*, *T. cruris*, *T. capitis*, *T. pedis*; (3) dermatitis (various); (4) furunculosis; (5) impetigo; (6) malnutrition with skin manifestations (avitaminosis and kwashiorkor could be included here); (7) prickly heat; (8) leprosy; (9) yaws, post-yaws "ichthyosis," plantar hyperkeratosis, pintoid yaws. Florid yaws, either